

Bariatric New Patient Assessment



Describe your personal goal for joining a weight loss management program: _

# of Years Overweight:	years		Desired Weight: lbs				
	ired weight by:		<u> </u>				
Maximum Lifetime Weight (non-pregnant): lbs Date:							
	ting to lose weight?No						
lf yes, plea	se check which diets:						
	Atkins		Mediterranean				
	Jenny Craig		Nutri-System				
	Keto		Slim 4 Life				
	Medifast/Optifast		Weight Watchers				
	Other:						
Have you ever tried using medication to lose weight?NoYes							
If yes, please check which medications taken:							
	Acutrim		Dexfenfluramine				
	Adipex-P		Didrex				
	Amphetamines		Fastin				
	Anorex		Fen-Phen				
	Benzphetamine		Phentermine				
	Dezatrim		Xenical				
	Other:						
Have you ever had weightloss surgery?NoYes							
If yes, which surgery? Date:							
it yes, whic							
SLEEP HABITS							
SLEEP HABITS	eeping?NoYes						
SLEEP HABITS Do you have difficuly sl	eeping?NoYes			_			
SLEEP HABITS Do you have difficuly sl If yes, desc	eeping?NoYes :ribe:			-			
SLEEP HABITS Do you have difficuly sl If yes, desc Do you snore?No	eeping?NoYes cribe: Yes Has anyone eve	er told you t	hat you snore?NoYes	-			
SLEEP HABITS Do you have difficuly sl If yes, desc Do you snore?No Have you ever been tol	eeping?NoYes :ribe: Yes Has anyone eve d you have obstructive sle	er told you t ep apnea?	hat you snore?NoYes	-			
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Please describe your relationship with each of the following:

		Excellent	Satisfactory	Unsatisfactory	N/A			
	Spouse/ Significant Other							
	Child(ren)							
	Other Family							
	Finances							
What do you do to handle stress? Do you have a history of physical, sexual, or emotional abuse?NoYes								
	If yes, describe:							
Have you ever attempted suicide? No Yes								
Have you ever received treatment for psychiatric illness (ex. Depression)?NoYes If yes, type of illness:								
ANESTHES	IA HISTORY							
Has any family member had a problem with anesthesia?NoYes If yes, describe:								
Have you had a problem with anesthesia?NoYes If yes, describe:								
Do you have difficulty moving your head side-to-side?NoYes								
Do you hav	ve difficulty opening or closing you	ır jaw?	NoYes					